

# Bluebonnet Home Health & Hospice

## INTAKE AND REFERRAL FORM

**REQUESTED START OF CARE DATE:** \_\_\_\_\_

Home Care: Yes \_\_\_\_\_ Hospice: Yes \_\_\_\_\_

Currently in Facility: Yes \_\_\_\_\_ No \_\_\_\_\_ Facility Name: \_\_\_\_\_ Expected DC Date: \_\_\_\_\_

Referring Person: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone/Pager #: \_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_ **TEL.#:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_

**Zip:** \_\_\_\_\_ **SS:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Medicare #:** \_\_\_\_\_

**Part A:** \_\_\_\_\_ **Part B:** \_\_\_\_\_

**PAYOR** \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

(Please fax Cover Sheet with pay source information History and Physical, Medication Record, Progress Notes, Surgical Records, Face to Face documentation and any other records that provide information to assist to identify potential problems and provide continuity of care to \_\_\_\_\_)

**PHYSICIAN NAME:** \_\_\_\_\_ **ADDRESS** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_ **TEL.#** \_\_\_\_\_

**NPI:** \_\_\_\_\_

Diagnosis: a. \_\_\_\_\_ b. \_\_\_\_\_ c. \_\_\_\_\_

d. \_\_\_\_\_ e. \_\_\_\_\_ f. \_\_\_\_\_

PT Referral/Evaluation Ordered: Yes \_\_\_\_\_ No \_\_\_\_\_

Wound Care: Yes \_\_\_\_\_ No \_\_\_\_\_

Orders from physician:

\_\_\_\_\_

\_\_\_\_\_

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